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To: Emergency and Ambulatory Care Departments
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Departments of Infectious Diseases
Departments of Dermatology
HIV/AIDS Service Providers

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Re: Infectious Syphilis among Men Who Have Sex with Men (MSM)

After a decade of decline, Massachusetts has witnessed a rise in infectious syphilis cases over the course of the last three years from a low in 1999, when 97 cases were reported, to a total of 197 for 2002. While the early to mid-1990's saw 1% or less of infectious syphilis cases among men who have sex with men (MSM), 113 of the 2002 cases, or approximately 60%, were among MSM. Of additional concern is the 50% prevalence of previously diagnosed HIV among those MSM presenting with infectious syphilis. Boston predominates with close to 50% of all infectious syphilis cases and over 50% for those among MSM.

Other states and cities in the United States are observing similar incidence in infectious syphilis cases among MSM¹. Most recently, the Centers for Disease Control (CDC) addressed the particular STD risk experienced by men of color and MSM who do not identify as gay². Case and partner interviews in MA and elsewhere indicate multiple factors contributing to the recent increase, including "HIV prevention fatigue", which appears to be limiting effective condom use and increasing numbers of sexual partners; expanded use of several substances, referred to collectively as "club drugs", in particular methamphetamine (popularly known as "crystal meth", "Tina", or "glass"), MDMA (better known as "Ecstasy", "X", or "E"), and ketamine (also known

as "Special K"); and changes in sexual partnering through the Internet, home parties, and other private venues.

The prevention responses recommended by the CDC and underway in Massachusetts require collaboration across multiple sectors. Clinicians are a critical point of contact for risk assessment, disease identification, treatment and prevention counseling through:

1. Improved identification of MSM in primary care and other clinical environments through sensitive and non-judgmental patient interviewing and routine sexual and drug risk assessment, including routine inquiry about the sex of patients' sexual partners and history of receptive anal intercourse, and current or recent substance use, with particular emphasis on club drug use in the context of sexual behavior.³
2. At least annual screening of sexually active MSM, including: HIV and syphilis serologies; culture or nucleic acid amplification tests (NAATs) for gonorrhea; urethral or urine NAATs for chlamydia of a sexually active MSM; pharyngeal culture for gonorrhea of all sexually active MSM; and culture for rectal gonorrhea and chlamydia of men who have had receptive anal intercourse. More frequent STD screening (3-6 mos.) may be indicated for MSM at highest risk.⁴
3. Vaccination of MSM against hepatitis A and B.
4. Client-centered prevention counseling focused on behavioral risk reduction for index patients and their sexual partners.
5. Referral of patients to needed mental health services and behavior change and support programs available through local HIV and STD prevention programs. A partial list of sites for referral is attached below. Additionally, in Massachusetts, patients and clinicians may call the statewide AIDS hotline to identify MSM-related prevention and care services.

Several resources are available through the Massachusetts Department of Public Health (MDPH) for assisting MSM and clinicians working with them. They include:

1. **STD diagnosis, treatment and disease reporting information available from the Division of STD Prevention at 617-983-6940.**
2. **STD training for clinicians which can be accessed through the STD/HIV Prevention Training Center of New England at 617-983-6945 and on the web at <http://www.state.ma.us/dph/cdc/stdtcmi/stdtcmi.htm>.**
3. **HIV and STD prevention and care services which can be accessed through the statewide AIDS hotline at: 1-800-235-2331 (TTD/TTY: 617-437-1672)**

Treatment information and a summary of clinical findings in syphilis follow.

¹ CDC. Primary and Secondary Syphilis – United States, 2000-2001. MMWR 2002;51 (No. 43).

² CDC. HIV/STD Risks in Young Men Who Have Sex with Men Who Do Not Disclose Their Sexual Orientation – Six U.S. Cities, 1994-2000. MMWR 2003;52 (No. 5).

³ CDC. Sexually Transmitted Disease Guidelines 2002. MMWR 2002;51 (No. RR-6).

⁴ Ibid.

SYPHILIS

TREATMENT RECOMMENDATIONS:

Treatment of primary, secondary and early latent syphilis:

Two doses (total) of Benzathine Penicillin G (BPG), 2.4 million units, IM, one week apart, is recommended, regardless of HIV infection status. Referral of cases to state-funded STD clinics for treatment is an option, but the initial dose should not be delayed pending availability of clinic sessions or an appointment. **Make sure you are using the appropriate formulation of BPG (Bicillin®L-A)**

Follow up:

Patients should be reevaluated clinically at the time of the second dose of penicillin. Repeat syphilis serologies (RPR or similar test) and clinical evaluation should be performed at one month, and then at 3, 6, 9 and 12 months to monitor serologic response to therapy and observe for reinfection.

Management of sexual partners:

Disease Intervention Specialists from the DSTDP are available to help with partner notification (call 617-983-6940). Sexual partners of infected people must receive preventive treatment immediately. **Do not wait for serologic test results on contacts.** Administer Benzathine Penicillin G 2.4 million units, IM, in a single dose. Referral of partners to state-funded STD clinics is an option, but treatment should not be delayed pending availability of clinic sessions or an appointment.

Screening:

It is very important for clinicians to ask patients about their sexual and social histories. Sexually active MSM who, in the last six months, report multiple sexual partners, new partner(s), anonymous partner(s), unprotected sex, and/or drug use with sex should be evaluated clinically and serologically for syphilis. Always screen for other STDs as well.

Reporting:

Syphilis is reportable to the DSTDP in Massachusetts. Please call the Division of STD Prevention for additional information and with questions about management and treatment of syphilis or other STDs.

SOME BASIC INFORMATION ABOUT SYPHILIS

Syphilis is caused by a corkscrew-shaped bacterium (spirochete), called *Treponema pallidum*. The spirochete does not live outside the human body and it is spread from person-to-person through direct contact with an infectious lesion. The spirochetes pass through intact mucous membranes and abraded skin. They are then carried by the blood stream to every organ in the body. Congenital syphilis results from passage of spirochetes across the placenta.

Primary syphilis is the most infectious stage of the disease. The first clinical sign is the chancre (ulcer). The lesion appears at the site of inoculation (21 days average, range 10-90 days), and is

highly infectious. Primary lesions are not confined to the genital area. They may be seen on the lips, tongue, tonsil, nipple, fingers and anus. Without treatment, the chancre will heal completely within 1 to 5 weeks (3 weeks average). If the lesion has been present >7 days, serologic tests will be reactive, but a lesion of less duration may be associated with a negative test.

Secondary syphilis is suspected primarily on the basis of the skin and mucous membrane lesions. The skin lesions are symmetrical and may be macular, papular, follicular, papulosquamous, or pustular. Moist papules and wart-like growths occur most frequently in the anogenital region (condylomata lata). Lesions of the mouth, the throat, and the cervix (mucous patches) frequently occur in secondary syphilis, as does generalized lymphadenopathy. Symptoms of secondary syphilis may last 2 to 6 weeks (4 weeks average) and may recur in untreated or inadequately treated patients.

Latent syphilis is the stage in which no observable clinical signs or symptoms are present to suggest infection, yet the serologic tests for syphilis are reactive. All cases of syphilis are latent at some time during the course of an untreated infection. For epidemiologic and patient management purposes, latent syphilis is categorized either as early (of less than one-year's duration) or late (of more than one-year's duration). In early syphilis, any period during which primary or secondary symptoms are absent is classified as latent.

Neurosyphilis can occur at any time during the course of untreated infection. All patients should be clinically assessed for neurologic signs and symptoms, regardless of stage of infection. If CNS involvement is suspected, a lumbar puncture should be performed and results should guide treatment and follow-up.